

**PM FORM 7.3.1 Seclusion and Restraint Reporting-
Level I Facilities**

FACILITY LICENSE #: _____ REPORT DATE: _____

Facility Name: _____

AHCCCS Provider ID: _____

Facility Address: _____

Contact Person/Title: _____ Phone: _____

Name and Title of Person Authorizing the event: _____

Reporting Information:

CIS Identifier: _____

Client Name: _____ Age: _____ SS#: _____

Client Behavioral Health Category: _____ (SMI, NSMI, SED, NSED)

Date/Time of Evaluation/Assessment: _____

Seclusion:

Date Administered: _____ / _____ / _____ Time: _____ am / pm

Name/Title: _____

Duration of Seclusion: _____ minutes / hours

Mechanical/Personal Restraint:

Date Administered: _____ / _____ / _____ Time: _____ am / pm

Name/Title: _____

Duration of Restraint: _____ minutes / hours

*If person is both secluded and restrained, complete **both** the seclusion and mechanical/personal restraint sections.

Drug used as Restraint:

Date Administered: _____ / _____ / _____ Time: _____ am / pm

Name/Title: _____

List drugs used as a restraint including dosage (other than PRN's): _____

Reason for Restraint/Seclusion (including justifying facts and behaviors)

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Was the person physically injured **DURING (not prior to)** the restraint or seclusion? ☐ Yes ☐ No

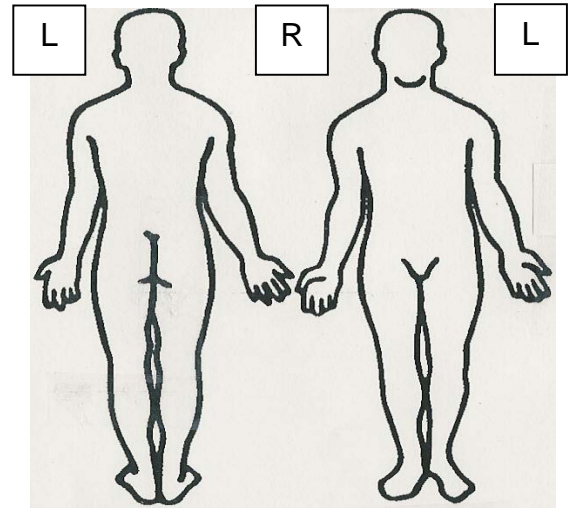
If yes, indicate:

1. Nature of the injury: _____

2. The level of medical intervention needed:

- ☐ None
☐ First Aid
☐ Medical (physician's order)
☐ Hospitalization
☐ Death

3. Indicate the location of the injury on the diagrams.



Indicate types of less restrictive alternatives attempted (including reasons for their failure).

Date, Time and Person who monitored client's status while in Seclusion or Restraint.

	Date	Time (am / pm)	Person monitoring
Start			
End			

Action(s) taken to prevent reoccurrence (individual and system):

Completed forms should be sent to the T/RBHA with which the facility is subcontracted. A form must be completed for each individual Secluded/Restrained.